ANNUAL REPORT OF CLAIMS INVENTORY

CHECK ONE:

To: State of California, Department of Industrial Relations Division of Workers' Compensation, Audit Unit ~ Attn: ARI Desk 2424 Arden Way, Suite 305 Sacramento, CA 95825

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COMPANY NAME

STREET ADDRESS		Self-Administered Insurance Company
CITY/STATE/ZIP		or Group Third-Party Administrator
P. O. BOX		Self-Administered Self-Insured
CITY/STATE/ZIP		Employer (private or public) Self-Administered Joint Powers Authority
Manager Name:		Combination of any of the following, but
Telephone:		only if administered under the same local management. (Check two or more):
Fax No.		Self-Administered Insurance Company or Group Self-Administered Self-Insured
E-Mail:		Employer
		Third-Party Administrator
Number of California workers' comp	ensation claims repo	orted at this location during the 2004 year:
Type of Claim Number		Number
• Indemnity	Indemnity with indemnity payments	
• Denied		
Medical-only	• Open claims (all years) end of year 2004	
Total:		
Signature		
Title:		
Date:		

NOTE: Insurer Groups (more than one underwriting company at the same location), third-party administrators, and combinations of the two must complete Part 2.

- Reports of Claims Inventory for each adjusting location of California workers' compensation claims are due by **April 1, 2005**.
- Failure to timely submit reports may subject you to penalty assessments of up to \$500 per location.